adverse-life-event-symptom correspondences. As noted by Dr. Levitan, such misattributions seem more likely to occur for amorphous adverse life events, such as the "nothing" adverse life event, than for clearly delineated events with specific onset times (e.g., deaths, romantic breakups, failures, conflicts, scares). Indeed, the "nothing" adverse life event is probably a mixed bag of causes, including both truly endogenous, unperceivable causes (e.g., vascular dysfunction, bioamine dysregulation) and external causes that are difficult to perceive (e.g., changes in the season, diet). Therefore, in agreement with Dr. Levitan, we feel that it is important to remember that participants' causal attributions may have sometimes been incorrect and that this is probably especially the case in dysphoric episodes, for which participants could not determine a cause.

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How "Supportive" Is Internet-Based Supportive Psychotherapy?

TO THE EDITOR: In their article, published in the November 2007 issue of the *Journal*, Brett T. Litz, Ph.D., et al. presented thought-provoking preliminary data on Internet-assisted, cognitive behavioral self-management of posttraumatic stress disorder (PTSD) symptoms (1). In a report that emphasized technology and downplayed human contact, however, it might have been helpful to clarify certain details pertaining to the control intervention. A randomized study is only as credible as its control intervention, which raises conundrums. What exactly is Internet supportive counseling—the control condition—in this trial? Furthermore, how much therapist contact did subjects actually receive?

One imagines that supportive counseling would require affective mirroring and interpersonal warmth. Although the study design included a 2-hour initial meeting between the subject and therapist and allowed "periodic and ad lib study therapist contact via e-mail and telephone" (1, p. 1677), it was not clear how much direct human contact and loving kindness the supportive counseling patients received. Although therapists were "instructed to be empathic and validating" (1, p. 1681), e-mail in particular can obscure affect. The fact that patients read about stress and its management and wrote about "daily nontrauma-related concerns and hassles" (1, p. 1681) does not actually explain how the treatment was supportive. The authors described data on the frequency of Internet sessions but not on the background e-mail and phone contacts. It may have been helpful if they had commented further on how frequent, how long, and how supportive the interpersonal contacts were in each cell.

Training good supportive therapists requires a great deal of work (2). Although the article emphasized the study web site, it omitted any description of the training and prior experience of the therapists involved. Did these same therapists back up both the cognitive and supportive web sites? If so, could this have introduced allegiance bias (3) into the study? Were attempts made to monitor therapist adherence to the respective treatments?

Finally, the authors described their cognitive web site at length, but relatively little about its supportive counterpart was mentioned. What features of the latter make it "supportive"?

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Dr. Litz Replies

TO THE EDITOR: We appreciate Dr. Markowitz's queries pertaining to the role of interpersonal contact in our Internet-based program. He raises a number of questions about our article, which he states "emphasized technology and downplayed human contact." It is important to note that our self-management cognitive behavioral therapy (CBT) *intentionally* reduces the role of human contact with the objective that more people will receive the care they need. The model is germane because many people 1) are reluctant to seek traditional services, 2) live in remote regions where expert care is unavailable, and 3) are unable to access services because the demand exceeds the resources. In an ideal world, there would be no barriers to care, but it is imperative to recognize the sobering reality that most survivors of trauma do not receive evidence-based mental health services (1). Telehealth therapies may be less efficacious because they do not provide intensive human connection and oversight, but there is an unequivocal public health need to overcome barriers to care through alternative methods of therapy delivery.

Dr. Markowitz suggests that a supportive counseling program should provide "interpersonal warmth." Our supportive counseling program followed previous psychotherapy trials by ensuring that it 1) did not contain active CBT skills and 2) involved the same therapist contact time (2). The issue concerning the telephone and e-mail contacts with patients in the respective conditions is an important one, and our analyses indicate that there were no significant differences between patients in the two conditions in terms of the total number or length of phone calls or e-mail messages. It should also be noted that the supportive counseling program resulted in a pre-/posttreatment effect size of 1.1, which is actually larger than most supportive counseling programs offered in traditional therapy formats (3). This suggests that the supportive counseling program was a change agent and provided

a reasonable Internet-based analog to a supportive psychotherapy comparison group for our trial.

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A Naturalistic Study of Consecutive Agitated Emergency Department Patients Treated With Intramuscular Olanzapine Prior to Consent

TO THE EDITOR: There is currently a larger body of evidence concerning injectable atypical antipsychotics relative to conventional antipsychotics, and expert consensus favors the use of injectable atypical antipsychotics in agitated patients (1). However, the American College of Emergency Physicians considers the evidence from extant studies of injectable atypical antipsychotics to be class II as a result of the populations used in modern trials. In the view of the American College of Emergency Physicians Clinical Policy Committee, findings from selected, consented, less agitated clinical trial subjects may not generalize to typical unselected, involuntary emergency patients (2). Injectable antipsychotics are used prior to medical assessment. Hence, data for efficacy and safety in unselected patients are critical, and observational studies in more relevant populations are required (3). To acquire a typical, unselected population of agitated patients, we obtained permission from the ethical committee of the Hospital "La Citadelle," Liège, Belgium, to treat patients who refused oral medication according to an established protocol. Under this arrangement, patients received the medication they would have received either voluntarily or involuntarily as usual care for agitated behavior. Consent for the diagnostic interview and use of the research data were obtained after resolution of the episode. Two subjects refused consent, and their data were destroyed. The data were made anonymous prior to the analyses reported in the present study.

Measures were collected prospectively for patients with acute agitation who presented consecutively to an urban emergency department. Measures included the Positive and Negative Syndrome Scale-Excited Component (PANSS-EC), Agitated Behavior Scale, and Clinical Global Impression Severity. Under local clinical policy, agitated patients who refused oral medication received olanzapine (10 mg, intramuscular). Patients with known substance use disorders, pregnancy, unstable diabetes, or intolerance to olanzapine were excluded. Assessments occurred 1) at baseline, 2) 2 hours postinjection, and 3) at discharge 12 to 24 hours postbaseline. Vital signs and adverse effects were assessed at these same time points. Diagnosis was ascertained using the Structured Clinical Interview for DSM-IV. The population reported in the present study included 21 women and 19 men (mean age=37.3 [SD=12.2] years) who were diagnosed for psychotic disorders (schizophrenia, schizoaffective disorders [60%]), bipolar disorders (mania [25%]), and personality disorders (15%). Physical restraint was required for 30 patients (75%), and four patients (10%) required subsequent injections. No other psychotropic medications were permitted.

Consistent with the expectation of higher agitation scores in unselected patients, the mean baseline PANSS-EC score was 27.5 (SD=4.23) versus a mean range of 12.39 to 19.7 in blinded, randomized, placebo controlled studies of olanzapine for the treatment of agitation (4–6). There were statistically significant reductions from baseline in PANSS-EC, Agitated Behavior Scale, and Clinical Global Impression Severity scores 2 hours after the first intramuscular injection (Figure 1). Consistent with reductions in agitation, there was a reduction in blood pressure (systolic/diastolic) of 8.2 (SD=3.1)/3.3 (SD=1.2) mmHg and in pulse of 8.7 (SD=1) beats per minute. There were no complaints of dizziness reported spontaneously or on enquiry. Although asymptomatic, seven patients experienced a 20 mmHg drop in systolic pressure and 10 experienced a 10 mmHg drop in diastolic pressure 2 hours postinjection. One patient's pulse decreased 20 beats per minute from 110 to 90. No patient had a pulse below 70 at any time point. In addition, no instances of excessive sedation were observed. Increases in Simpson Angus Scale and Barnes Akathisia Scale scores were not statistically significant.

To our knowledge, this is the first observational study of olanzapine with consecutive enrollment and treatment prior to consent. Data are consistent with the findings of controlled trials in selected populations. However, the magnitude of effects should be interpreted cautiously, since the benefits of antipsychotics appear twice as large in studies without placebo comparison relative to those with placebo comparison. No conclusions can be reached about the relative efficacy of olanzapine and standard treatments such as haloperidol. The data also confirm the need for vigilance with respect to vital signs. Our sample is not large enough to inform the frequency of more serious but less common adverse effects.

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